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THE MEDIC AS AN INSTRUMENT OF NATIONAL POLICY OR WHAT IN THE WORLD IS THE DEPARTMENT OF DEFENSE DOING IN MEDICAL HUMANITARIAN ASSISTANCE?

BY

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THE MEDIC AS AN INSTRUMENT OF NATIONAL POLICY
or
WHAT IN THE WORLD IS THE DEPARTMENT OF DEFENSE DOING IN MEDICAL HUMANITARIAN ASSISTANCE ?

AN INDIVIDUAL STUDY PROJECT

by

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ABSTRACT

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The Department of Defense has become increasingly active in providing medical humanitarian assistance to countries around the world. This study looks at the historical involvement of military medicine in the development of public health infrastructures in three places: the Philippines after the Spanish - American War; in Vietnam; and in the Dominican Republic. It then examines the laws and policies that allow for the implementation of medical humanitarian assistance. The lessons learned are then looked at in the context of recent medical humanitarian action in Honduras. Finally, recommendations for future military medical aid are made, combining the lessons learned with the current mechanisms of the Department of Defense for providing that assistance.

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INTRODUCTION

Within the past decade, the Department of Defense (DOD) has become proactively involved in providing medical humanitarian assistance to countries around the world. This is a radical departure from the traditional military medical role. Or is it? What is the historical evidence of involvement of military medical people, "medics", in the development of medical or public health services in other countries? This study does not look into ad hoc military contributions to disaster relief, but rather into preplanned, deliberate efforts to improve the health services of a particular people.

This analysis of U.S. medical assistance in foreign areas has three components. The first, and easiest, is what U.S. military medicine has done in this arena. This study will examine our involvement in three countries: the Philippines after the Spanish-American War (1898-1902); Vietnam (1962-1973); and the Dominican Republic (1965). The second component is "lessons learned" from U.S. involvement in military medical humanitarian assistance. This will provide a common thread that will run throughout the study. The third, interrelated but far more difficult to address, is the appropriateness and the effectiveness of Department of Defense medical humanitarian efforts. Is it "effectiveness" in responding to basic humanitarian impulses of the American citizenry; effectiveness

in winning and maintaining friends for the United States; or, effectiveness in helping to develop viable and durable health services? Objective data are essentially non-existent to answer any of these effectiveness questions. Subjective data abounds, of which I will offer my own.

Traditionally, if the United States government has been involved in medical humanitarian assistance it has been through civilian departments and agencies, primarily the Department of State (DOS); the United States Agency for International Development (AID); and, to a much lesser degree, the Peace Corps. There are those, especially in these latter groups, who believe that DOD should leave well enough alone. Critics of DOD medical programs argue that the basic mission of the military is antithetical to humanitarian assistance and that the civilian groups, both governmental and private, are capable and structured to do that mission. Similarly, there are those in DOD who argue that resources diverted to humanitarian assistance should be redirected to the more traditional military missions.

The geographic commanders-in-chief (CINCs), and low intensity conflict (LIC) concepts, provide counter arguments. Key people in the LIC arsenal include medics, special operations forces, engineers, military intelligence personnel, and perhaps military police. With funding for security assistance diminishing these highly cost-effective forces are becoming an increasingly desirable option in the CINCs armamentarium.

In addition, invaluable training and experience is gained by those providing the assistance.

Clear authority for medical humanitarian assistance has been given to DOD. Specific processes and procedures of coordination must be followed for its implementation. This analysis will focus on the Office of the Assistant Secretary of Defense for International Security Affairs (ASD/ISA), Humanitarian/ Civic Assistance (HCA) and that office's role in medical humanitarian assistance.

This study is a look at where we have been in our efforts to provide medical humanitarian assistance; the evidence for how well we have done; the lessons we have learned; the legal, fiscal, and structural limits on what we can now do; and finally, poses the question, which way from here?

THE PAST AS PROLOGUE

The first significant use of military medical assistance in foreign areas began with the McKinley administration. In May 1898, following Commodore Dewey's naval victory over the Spanish squadron in Manila Bay, McKinley committed American ground forces to the Philippines. He had no contingency plans and issued, essentially, no policy guidance to his commanders, except to act with "benevolence." In the ensuing four years, Army medical officers, directed and encouraged by their commanders, were to rebuild the public health infrastructure of the Philippines.[1] Until that time, foreign medical aid in the form of U.S. humanitarian military assistance was de minimus care that was given incidentally, at minimal cost, to civilians.

This chapter surveys the military medical humanitarian assistance in several countries where the United States committed ground forces, and then used its medical forces to assist the local populace. The Philippines following the Spanish - American War (1898-1902), and Vietnam (1962-1973), were countries where the U.S. made major military commitments. The Dominican Republic crisis (1965) will be reviewed as a smaller scale and limited duration venture. Honduras will be addressed in a separate section from a personal point of view.

Army medical disaster relief will not be discussed. However, it should be noted that both the advances in modern medicine, and the increased involvement of the United States in world affairs since the beginning of this century, have encouraged the U.S. to participate in disaster relief. The Army, for awhile, was the only federal organization with the ability to provide such aid. Gaines M. Foster, in his book, The Demands of Humanity (1983), adds that part of the motivation for U.S. relief aid, in addition to purely humanitarian concern, was "national prestige, and commercial considerations."[2] Regardless of the motivation for their use, "medics" began to be used in a role to support national policy.

The Philippines

When American troops arrived in Manila in June 1898, the political situation was unclear in Washington; unclear to Major General Merritt, the U.S. commander in Manila; and unclear to the Filipino revolutionaries, lead by Emilio Aguinaldo. United States sovereignty or Philippine independence was the issue, and Washington had not made up its mind. Receiving conflicting, but mostly encouraging reports, McKinley decided it was not only in U.S. interests, but also in Philippine interests, that the U.S. would assert its right to sovereignty in the Philippines

Philippines as agreed to in Paris during the Spanish - American Peace Conference. Unappreciated by McKinley was the fact that the revolutionaries already controlled most of the archipelago, to include their standing army encircling Manila.

It is ironic that the roots of the two major, nationalistic insurgencies that the United States has confronted in this century came out of conditions towards which Americans hold sympathy. The Filipinos were the urbanized, educated class, basically seeking the same freedoms and conditions that existed in Spain. Ho Chi Minh was a representative of the mandarin class for whom nationalism and not, initially, communism was the driving force. In the Philippines the goals of the insurgents were basically congruent with those the United States had for the Philippines, except for the Filipino desire for total independence. The United States strategy, which included pacification, was successful in overcoming the Philippine insurgency.

From June 1898 to February 1899, the U.S., motivated by humanitarian instincts, had acted benevolently toward the Filipinos while it was deciding its Philippine policy. In February 1899, war between the insurgents and the U.S began over a trivial incident. In spite of the open hostility, pacification continued and became the main component of the military strategy.[3] Key to pacification was developing and strengthening schools, municipal government and public health.

U.S. public health efforts began in Manila and became the basic model for the rest of the Philippines. The Chief Surgeon (initially Major Frank S. Bourns, MC) became the general director of the Philippine Board of Health where medical professionals, both American and Filipino, served. Under the Board of Health came the Department of Sanitation. Communicable infectious diseases were a serious threat, and efforts were immediately started to clean up the city. Water sources were protected and garbage removed from the city. Sewage removal had been a continuous problem and a system to haul it into the countryside was started. Inspection of homes and public gathering places was scheduled and became routine. Clinics for the indigent were established and free medicines given. There is no doubt that these measures brought a higher level of health to the Filipino people, but they often conflicted with long held cultural habits and traditions.[4,5]

The Manila Board of Health, in effect, became the higher headquarters for the provincial public health efforts. The medical officer of a U.S. military unit became that region's public health officer. Because of the importance of the public health program in the pacification campaign, the number of medical officers increased to one "surgeon" per 176 men, and $150 was allotted for every 1,000 civilian patients.[6] It was common for the medical officers, although against regulation, to use designated military medical supplies to treat the local people.

An interesting sidelight was the successful effort to vaccinate against smallpox. Refrigeration needed for long term storage of the vaccine was unavailable, so bovine farms, originally started by the Spanish, were reopened for the production of vaccine. Inoculation directly from one person to another was an additional method used to achieve widespread vaccination of the population.[7]

Two unrelated problems tended to have a negative influence on medical humanitarian assistance. The first was the cultural differences between the provider of assistance and the recipients. The second was that nothing could be accomplished without basic security for the people involved.

Ken DeBevoise in his dissertation on the Philippine - American War pointed out cultural differences:[8]

> Different cultural and practical approaches were also a factor. The Americans, and especially the Army, tended to see only the medical aspects of the problem, which could be solved if everyone would simply cooperate. The fact that the war and the U.S. presence had created a dependency on American dollars on the part of the women (prostitutes) and their families was considered irrelevant. Filipinos were more likely to see the complexities of the problem, especially its human and economic aspects.

Gates addressed the problem of security:[9]

> Revolutionary terror tactics and the inability of the Americans to protect municipal inhabitants, however, more than offset the gains made by the policy of benevolent pacification throughout most of 1900.
>
> Benevolence could change the attitudes of Filipinos toward Americans, but the change was of little significance or value until techniques of

pacification were initiated to stem terrorism and give protection to townspeople. This combination was evident in 1901.

One purpose of this study is to find evidence of the effectiveness of medical humanitarian assistance in the development of a country's public health services, especially in a counterinsurgency (LIC) setting. As will be presented in another section, there are essentially no objective data.

Perhaps the closest one can come to assessing the effectiveness of the pacification efforts is to note commentary from the time. Elihu Root in referring to the qualities of the American soldier said, "The moment that the enemy ceases to fire ...[he] is ready with open hand,...to heal the sick, to succor the poor, to teach the ignorant, to set up the arts of peace and to turn the scene of warfare into the smiling land of plenty." Gates states, "...the Army's public health work was an important force for pacification, bringing to the Filipinos vivid evidence of the humanitarian and benevolent intentions of the United States."[6] He added, "The American policy of benevolence and the many humanitarian acts of the Army throughout the war played a much more important role in the success of the pacification campaign than fear did."[10]

The lack of significant experience by the U.S. Army in civil affairs at the time of the Spanish - American War may have been an unforeseen advantage: "Within the Army and the American government there was no group of 'experts' with

preconceived ideas on how to run a colonial government, and the very absence of this group made possible the successful, pragmatic approach that the Americans did use." Unquestionably the most important qualities needed to combat the insurgency were "patience, dedication, and a willingness to remain on the job for an extremely long time."[11]

The main lesson learned from the Philippine experience is that counterinsurgency strategy, which includes pacification, can be effective. An essential part of pacification is the development of a public health infrastructure

In Cuba, during the time of the insurgency in the Philippines, U.S. medical officers instituted and oversaw the running of the public health efforts in the two separate periods of U.S. occupation. Unfortunately, public health efforts deteriorated after each U.S. departure. There were several reasons for this deterioration. First, unlike the Philippines, where an American civil authority continued after military control ceased, Cuba did not have a continuing U.S. presence. Second, there were inadequate resources, in people and money, to maintain the public health programs at the level established by the U.S. And third, the U.S. expectations of the level of concern and expertise of the Cubans was not realistic.

It is interesting to note that General Leonard Wood, a former medical officer, was the military governor of Cuba, and that Major Walter Reed did his landmark work on yellow fever in Cuba.[12]

Vietnam

It all came together in Vietnam: as a model of how medical humanitarian assistance could help build an infrastructure in a developing country, this was it. Unfortunately, larger problems obscured the fruits of the medical labor.[13]

By the summer of 1962, AID had its first surgical team operating as part of the Provincial Health Assistance Program (PHAP). The AID plan was to send teams of civilians to provincial hospitals and to train Vietnamese physicians, nurses, and technicians. Despite great effort and support from allied nations, the project met insurmountable odds in a country torn by guerrilla war.[14]

With the build up of combat forces in 1965, the Secretary of Defense directed that the medical services prepare a program to assist the civilian effort. The goal was the development of an independent, self-sustaining health service in Vietnam.

The health service effort was initially a joint venture between AID and the United States Military Assistance Command, Vietnam (USMACV), and given the name Military Provincial Health Assistance Program (MILPHAP). Eventually the controlling committee structure included U.S. military and Vietnamese civilian medical officials.[15] The diversity of the effort is seen in the working committees. From 1968, there were committees for hospital construction, medical supply, medical education and training, preventive medicine, and public health.

The organizational structure of AID in Vietnam is of interest. There was an overall country director and subordinate to him were five associate directors. One was the Associate Director of Long-Range Development. Under him was the Assistant Director for Public Health. This obscure position for the second largest AID program in Vietnam (the largest being Public Safety) was, according to Col. William Moncrief (later MG), due to "administrative in-fighting." He also stated that because there were no career medical people in AID, that AID officials felt the itinerant medical people were new to AID programs and needed supervision. Therefore, they were not given more senior directorates.[16] Another quirk in the system was that Col. Moncrief was assigned to AID, paid by AID funds, but did not receive credit for his years of service in AID toward his active military service.

Col. Moncrief's comments on the medical objectives of humanitarian assistance are worth emphasis.[17] They have become part of the lessons learned from Vietnam and are applicable throughout the LIC spectrum. They also form part of the "principles learned" presented at the conclusion of this study. Following is the author's distillation of Col. Moncrief's comments into 6 points:

1. The standard of care sought must be slightly better than that currently available but not a wholesale adoption of American medical standards. The tendency for Americans is to attempt to provide care to the standards to which they are trained.

2. The host country (Vietnam in this case) wants and needs the development of a lasting public health infrastructure, not curative medicine that is of value to an individual patient but is short lived. Americans seem to prefer to give direct care which provides quick professional gratification.

3. For continuity of care there must be commitment to a particular area. If the health worker can only safely helicopter in, then we should give up on that area until safe conventional entry can be made with their host nation counterpart.

4. Counterparts should have similar medical and social status. As an example, if the local medical authority is a health care

worker and not a physician or nurse, the U.S. should send in a corpsman rather than a physician or nurse. Otherwise it becomes the American program, not that of the host country.

5. Do not overtrain. As an example, Vietnamese nurses who were given several years of medical training became fluent in English, and subsequently were lost to higher paying jobs as translators.

6. Beware of competition with the established system. Hostile co-professionals may try to subvert real or perceived competition.

In accord with the above guidelines, each MILPHAP team - doctrinally composed of three medical corps officers, one medical administrative officer, and 12 corpsmen - was to work under the supervision of the provincial chief of medicine. By 1970 there were teams in 25 of the 44 provinces, distributed evenly between the Army, Navy and Air Force.[15] Most desirable for the teams were general medical officers with an interest in preventive medicine. Pediatricians and partially trained surgeons were also highly desirable.

While MILPHAP was usually hospital based and provided a permanent presence, the Medical Civic Action Program (MEDCAP) was mobile and primarily designed for outpatient care to the Vietnamese. Originally a MEDCAP team was made up of Special

Forces personnel. Much, if not most, of the care was given by well trained corpsmen who worked with their Army Republic of Vietnam (ARVN) counterparts, usually in the hamlets and villages. Part of the MEDCAP mission was to help train local health workers.[18]

An interesting MEDCAP anecdote was related by Major John Erskine, MSC, who was actually part of a Special Forces Military Training Team (MTT) in Thailand, but whose story is germane. In response to the question, "What were the particular methods used to combat counterinsurgency from the medical viewpoint?", Major Erskind replied:[19]

> We were teaching basic public health type things - types of simplifying waste disposal systems, water purification, very very basic medical type stuff. We did not do any treatment at all in the villages. Rather we were teaching members of the Thai Army how they could use medical techniques to gain the confidence of the people in the villages and project that the Thai Army could sponsor in the villages - to improve the general health. One interesting story... they had a lot of dug dirt wells, very muddy....we were going to work with the Thai government and recommend they install regular old fashion style pumps in the villages. We went out to check on that thing after it was all done....they were mostly using the water from the well to wash their clothes in. Still drinking out of the mud well, we inquired as to why that was since the water was much cleaner and clearer and everything else. The water out of the pump did not taste right it was not thick enough. You can bring in American ways of doing things but you can't necessarily make any immediate changes in the way people live and have grown up in their society as to what is acceptable.

After the build up of American forces in 1965 and the greater availability of medical troops, MEDCAP II began and

worked parallel to what then became MEDCAP I. In MEDCAP II, effort was made to continue to work through the ARVN, but many more U.S. units became involved in the program. It often became an added duty to be done in off-duty time. Most of the care was acute in nature but some preventive medicine programs, especially immunizations, had lasting effects. The dental and veterinary forces were major contributors and became known as DENTCAPs and VETCAPs respectively.

A program not as well known, but designed to meet the needs of a civilian population caught in war, was the Civilian War Casualty Program (CWCP). Originally this program was designed to build hospitals to care for the civilian casualties. American military medical personnel staffed the hospitals. After 1968, civilian casualties were admitted to military hospitals on a space available basis. This also allowed the patients to be in hospitals nearer to their homes, and consequently was more acceptable to the Vietnamese patients.[20]

The MEDCAP model is similar to what today is called a Medical Readiness Training Exercise (MEDRETE). The name change emphasizes the value of the medical training to the U.S. medic. In peacetime, training is a key factor, and "readiness" the byword necessary for funding. However, this wording obscures the great value these exercises have as part of counterinsurgency and civil affairs efforts.

Dominican Republic

The Dominican Republic Crisis of 1965 offers a vignette of the role of medical humanitarian assistance in a relatively small contingency operation.[21]

When the XVIII Airborne Corps was sent into the Dominican Republic as part of the Inter-American Peace Forces, its medical units were originally organized to maintain and support the fighting forces. Initially, civilian casualties were overestimated, and the American ambassador requested additional medical units which, consequently, were given a high priority in shipment. The 82nd Airborne commander, who had not requested a change from the original plan for more medical units, was chagrined to see a steady stream of red crosses rolling off the early arriving aircraft.

In fact, there were not many casualties, and the employment of medical units was based primarily on humanitarian and public relation considerations. Ad hoc Civil Medical Assistance Teams were formed, usually consisting of two medical officers, two senior medics, two interpreters, and six ambulance drivers. More serious cases were sent back to clearing stations or the field hospital. Because of the frequency of dental complaints, dentists were soon added to the teams. Before these teams went into a village, an advance man would seek out the head man,

to determine if the American team would be welcomed, to ascertain the medical need, and to spread the word of the team's coming.

In the Dominican Republic the highly successful, but - as usual - unsung, medical heroes were the 714th Preventive Medicine Detachment and the 69th Veterinary Food Inspection Detachment.

Within a few weeks of the U.S. employment, the chief military surgeon and the Ministry of Health agreed that the small number of civilian casualties had all been cared for, and that the civil affairs effort would now be to support the local medical people with supplies. The local medical facilities would be the sole source of care, except for emergencies. Some physicians complained that the military was ruining their practice, but they learned to refer their own poor patients to the military. Consequently, the XVIII Airborne Corps ordered all assistance stations closed. It was not long, however, before the 82nd Airborne Division commander ordered the reinstitution of the medical teams for the countryside. Their value in establishing good will, people-to-people, was too valuable to pass up.

Medical supplies for civilian use in the Dominican Republic were to be supplied by the Red Cross. However, military medical supplies were often donated because of their easy availability. The Navy and Air Force transported some of the Red Cross

supplies. This foreshadowed the Denton Amendment twenty years later, allowing for the free transport of humanitarian supplies by military transport.

What were the medical lessons learned in the Dominican Republic? First, the medical units were not prepared to provide civilian care. Only after battle casualties were cared for, would combat commanders be in a position to provide civilian humanitarian assistance. Second, personnel and supplies must be available to treat the large number of noncombatants. Third, the medical threats and needs of the region must be known and anticipated so that adequate supplies are made available. In this case, tropical disease medications were lacking. Fourth, second order effects must be anticipated. Local physicians felt threatened by the free medical care provided by the U.S. military. A policy of caring primarily for indigent patients, as well as providing medical supplies, such as vaccines, through the local public health system, helped to alleviate their concerns. Efforts to re-establish local control of the hospitals and the public health system were started as quickly as was possible.

This chapter has considered examples of military medical humanitarian assistance rendered in the presence of sizable numbers of combat troops in the Philippines, in Vietnam, and in the Dominican Republic. In each case, U.S. medical aid was part of the overall U.S. strategy to build a strong, viable

government for a foreign country, which would act in harmony with U.S. national interests. Today, military medical aid is often seen in the context of low intensity conflict, where humanitarian assistance usually comes before any need for combat troops. The principle remains the same. A healthy public health service is an ingredient of a stable government.

Endnotes

The Past as Prologue

1. John M. Gates, Schoolbooks and Krags, pp. 3-7.

2. Gaines M. Foster, The Demands of Humanity, p. 52.

3. Gates, p. 84.

4. Ibid., p. 60.

5. Foster, p. 29.

6. Gates, p. 136.

7. Foster, p. 35.

8. Ken DeBevoise, The Compromised Host, p. 277.

9. Gates, p. 278.

10. Ibid., p. 277.

11. Ibid., p. 285.

12. Foster, pp. 27,41.

13. Elray Jenkins, COL, Medical Civic Action, pp. 8-12.

14. Spurgeon Neel, Vietnam Studies, p. 162.

15. Ibid., p. 163.

16. William H. Moncrief, COL, Oral History, Office of the Surgeon General, Medical History Unit Collection Inventory, 23 May 1968, p. 10.

17. Ibid., p. 20.

18. Nell, pp. 164-165.

19. John Erskine, MAJ, Oral History, Medical History Unit Collection Inventory, p. 6.

20. Neel, p. 166.

21. Darrell G. McPherson, The Role of the Army Medical Service in the Dominican Republic, pp. 6-51.

UNDER WHOSE AUTHORITY ?

That the U.S. military medical establishment has had episodic involvement in the medical affairs of other countries is documented in the preceding chapter. However, such involvement was associated with the presence of U.S. combat trocps and was part of larger operations. Today, by law and policy, military medicine is in the forefront of giving small, but growing, aid to medical infrastructures of developing nations where U.S. combat troops are not usually present. Until 1984, United States humanitarian assistance efforts were the sole responsibility of civilian branches of government. What, then, is DOD's authority to be directly involved and how has that authority evolved?

DOD's direct involvement in medical humanitarian affairs began in Central America in the early 1980s. Nicaragua had turned to communism and had become a crack in the basic U.S. containment strategy. El Salvador was in overt civil war. Guatemala, internally, was in turmoil. Honduras, the poorest, was showing signs of greater democratic life. Honduras, therefore, became the place where the reviving LIC doctrine of "nation building" could be tried with the genuine hope of helping a developing country. (The term "reviving" is used

because it reflects what was basically an updated version of the counterinsurgency doctrine of the 1960's.)

In close concert with the Honduran government, the U.S. military began a continuing presence. The U.S. had three major emphases in Honduras. First, was the support of the Contras along the Honduran - Nicaraguan border. Second, was the support of the governmental forces of El Salvador. And third, was the assistance provided to the Honduran government in its development. This latter emphasis relied heavily on humanitarian assistance, the role of the engineers and medics being key components. The engineers began building a road connecting two isolated regions of the country (unrelated to the Contra support), digging wells, and clearing airstrips (sometimes related to Contra support). The medics opened their field hospital to care for local Hondurans, and started medical readiness training exercises (MEDRETEs).

Executive Order 12163 of 1979 and other congressional legislation had previously limited DOD initiated humanitarian actions to instances integral to defense or to times of imminent danger.[1] Those limitations were loosened in 1985 by two pieces of legislation. In reaction to a Government Accounting Office (GAO) report that, without authority, DOD had expended appropriations in U.S. Southern Command (SOUTHCOM) for humanitarian assistance projects, Senator Stevens sponsored, and the Congress enacted, an amendment to the 1985 Appropriations

Act. This Stevens Amendment allowed DOD to use Operation and Maintenance (O&M) funds for humanitarian projects "incidental to" Joint Chiefs of Staff (JCS) directed, coordinated, or approved exercises overseas.[2] The related Denton Amendment to the DOD Authorization Act of 1985 allowed for the free transport of humanitarian supplies to Central America on military aircraft.[3]

During this same period, Secretary of Defense Weinberger approved the Humanitarian Assistance Task Force Report which gave the Deputy Under Secretary of Defense (Policy) overall responsibility for coordinating DOD humanitarian activity.[4] Five concerns were addressed: surplus property disposal, transportation, disaster relief, civic action, and medical care.

However, all was not harmonious within DOD. There was agreement that the geographic CINCs needed an enhanced ability to expand their cooperation with friendly governments, but how to fund that enhancement was another question.[5] The Office of the Secretary of Defense (OSD), the Army, and the CINCs wanted to ask Congress for authority to include the funding in the regular DOD budget. The Office of the Joint Chiefs of Staff (OJCS), the Air Force, and the Navy believed the security assistance budget was the better way to get increased funding. This latter view reflected two concerns. The first was political: congress had traditionally used security assistance as the means to help friendly foreign governments, and might,

therefore, reject any request to manage the funding through the regular defense budget. Consequently, the Total Obligation Authority (TOA) might be at risk. In addition, a regular budget request would conflict with the Department of State in its traditional role as nation builder. The second concern was more basic: an expanding DOD role in humanitarian assistance might compromise service readiness and warfighting missions.

This was the time just before the passage of the Goldwater-Nichols Act (1986), and it was evident that Congress was going to strengthen the power of the CINCs. Deputy Secretary of Defense Taft supported the CINCs in their budget recommendation, and it was decided, therefore, to ask Congress for expanded authority and funding in the DOD budget. For funding, each service component would act as an executive agent for the CINC.

DOD also decided to request that the legal authority which had restricted humanitarian aid to Central America, be expanded to include developing countries worldwide. Indeed, current laws and statutory provisions now authorize three forms of HCA.[6]

1. HCA given under 10 U.S.C. 401(c) (1), conducted <u>in conjunction with</u> military operations, approved by the Secretary of State and reported to Congress on 1 March each year. This is "Program 10" (host nation support) money. How this is coordinated and approved will be covered in subsequent paragraphs.

2. HCA given under 10 U.S.C 401(c) (2), de minimus in nature, incurring a minimal expenditure of O&M funds and not requiring Secretary of State approval. This is "Program 2" money. Section 401(c) (2) required reporting to Congress on 30 September each year, but the Army Judge Advocate General and the Office of Humanitarian Assistance agreed that the Senate-House Conference to resolve differences in the bill exempted this reporting requirement. The Conference Committee also set out rough guidelines for de minimus medical assistance:[7]

> ...the conferees were concerned that modest activities could generate burdensome paperwork because of the requirements for prior approval, separate financing, and annual reporting. The conferees, therefore, exempted de minimus activities from this section. The conferees did not put a specific dollar ceiling on the definition of de minimus but wish to make clear they had in mind activities that have been commonplace on foreign exercises for decades. These would include a unit doctor's examination of villagers for a few hours with the administration of several shots and the issuance of some medicines--but would not include the dispatch of a medical team for mass inoculations. De minimus would also include the opening of an access road through trees and underbrush for several hundred yards--but would not include the asphalting of any roadway.

3. HCA given which is authorized under the Stevens-type of incidental expenditures in the DOD Appropriations Act. In FY 90 it was section 9031 of Public Law 101-165. Since 1988 the wording has remained essentially the same and limits assistance provided incidental to authorized operations, but not de minimus in nature (see above). Expenditures must be reported to Congress

on 30 September each year, but do not require Secretary of State approval. Funding is general purpose O&M, "Program 2" money.

It is DOD policy that humanitarian and civic assistance provided in conjunction with military operations (10 U.S.C., 401) meet the following requirements:[8]

> 1. HCA activities under the Directive must promote the following:
>
> a. The security and foreign policy interests of both the United States and the country in which the activities are carried out.
>
> b. The specific operational readiness skill of the Armed Forces members who participate in the activities.
>
> 2. HCA activities carried out under this Directive shall complement, but not duplicate, any other social or economic assistance that may be provided to the country concerned by any other U.S. Department or Agency. Such activities shall serve the basic economic and social needs of the people of the country concerned. They should have support of civilian leadership and benefit a wide spectrum of the community.
>
> 3. HCA carried out under Section 401 of 10 U.S.C. may not be provided (directly or indirectly) to any individual, group, or organization known to be engaged in military or paramilitary activity.
>
> 4. HCA projects or activities in any foreign country require the specific prior approval of the Secretary of State for such assistance.

How does HCA medical aid work in practice? It must be clearly understood that anything, military or civilian, that is done by the U.S. in a foreign country is under the control and supervision of the United States Ambassador. To ignore that fact is to invite disaster to any planned project. The Ambassador usually works through a "country team" that includes

all the major U.S. government representatives in the country. Included are the military chief for security assistance, and the chief of the Agency for International Development (AID). AID is the lead agency for any developmental assistance which includes medical humanitarian aid.

In the early stages of planning, the CINC's representative coordinates closely with, and gets the approval of, the country team, especially the AID representative. The CINC then submits a project nomination list with justification and priority to ASD(ISA) and CJCS. For the Program Objective Memorandum (POM) cycle, the CINC also submits his program requirements to the ASD(ISA), CJCS, and to the Secretaries of the Military Departments with rationale and estimated costs for the next five years. Provisions are made for emergent, high priority projects.[8,9]

The single coordinating point of contact with all other executive agencies is the Office of Humanitarian / Civic Assistance of ASD(ISA). HCA coordinates with OJCS, ASD (Health Affairs) and ASD(SO/LIC), if necessary, and especially with the Department of State. This coordinating arrangement is working efficiently and smoothly. It is not unusual for an Ambassador to call directly to ASD(ISA)/HCA to facilitate the process.

Most geographic CINCs now have an Office for Humanitarian and Civic Assistance which works closely with the Command Surgeon's Office. An excellent current example is the work coming out of the SOUTHCOM Surgeon's Office:[10]

> The Regional Medical Strategy, developed by the SOUTHCOM command surgeon's staff, is the first such document for a unified command and the first functional area strategy within the SOUTHCOM joint staff. Building on the command Regional Security Strategy, the medical strategy looks at the region as a whole and each country individually in terms of health threat, military and civilian medical capabilities, and SOUTHCOM medical objectives. Formalization of the strategy serves to ensure that all medical activities in the theater are consistent with US security interests and the CINCs objectives and priorities.

The SOUTHCOM Regional Medical Strategy serves as a model for U.S. medical assistance efforts. Central to the program is that the assistance is designed to the individual needs of each host country. This individual approach allows for the application of the lessons learned from prior U.S. experience. As examples: the standards set for medical assistance in Panama may be more sophisticated than those established in Honduras; a U.S. physician may be the appropriate counterpart for an assistance program in Costa Rica, and a medical sanitarian the preferred counterpart for a team working in the mountains of Bolivia.

Endnotes

Under Whose Authority ?

1. Richard H. Goldstein, M.D., The U.S. Military and Humanitarian Action - An Expanding Role, p. 1.

2. U.S. DOD, DOD Humanitarian Assistance Program, Command Briefing, ASD/ISA, p. 3.

3. Ibid, pp. 5-6.

4. William H. Taft, IV, Designation of DOD Coordinator and Director for Humanitarian Assistance, p. 1.

5. U.S. DOD, Unified Commander's Conduct of Cooperative Programs with Friendly Nations, pp. 1-6.

6. U.S. Southern Command, Funding for Humanitarian and Civic Assistance Projects in Andean Ridge Countries, pp. 1-2.

7. U.S. Congress, Senate-House Conference Report, Humanitarian and civic assistance provided in confunction with a military operation (sec 333), p. 1.

8. U.S. DOD, Directive Number (Pending), p. 3.

9. U.S. DOD, Coordination of Humanitarian and Civic Assistance in Conjunction With a Military Operation, pp. 1-2.

10. Edwin H. Carns, "Medical Strategy," Military Review, February 1989, p. 37.

ONE MAN'S VIEW

This study has tried to look somewhat objectively at historical examples of the U.S. medic's contribution to the "nation building" of foreign governments friendly to the U.S., as well as the DOD structure which allows ongoing military medical humanitarian efforts. No hard objective data have been found to substantiate the long term effectiveness of any of these efforts. That is not to conclude that they are ineffective. In fact, from the point of view of training medics, one could surmise great effectiveness. This chapter will delve into the subjective experiences of the author and be presented in the first person. If nothing else, it will focus on the issues facing military medical humanitarian assistance.

Shortly before arriving at Palmerola Air Force Base, Honduras, in February 1986 as the Joint Task Force - Bravo (JTF-B), Medical Element commander, I was given a letter written by a Peace Corpsman to his congressman.[1] The Peace Corpsman was a public health educator in a Honduran pueblo, striving "to teach that it is possible to improve one's own standard of health, hygiene and nutrition through education, hard work and acceptance of responsibility for changing situations encountered." He came to "deeply regret" his participation

in hosting a MEDCAP (later MEDRETE). Over five hundred Hondurans had come to his village because of the American's visit, and "there was nearly a feeling of religious devotion and expectation of that miraculous cure sought by those on the verge of despair." What he saw contradicted what he knew of sound medical practice and development strategy. He did not question the high motives of the medics involved. His criticism centered on the quickness of exams necessitated by large numbers of patients; prescriptions for too much medication without knowledge of informed usage; the treatment of all children for intestinal parasites; and the dispensing of vitamins which would have only transient effect. His most profound criticism was that the people had raised expectations that, within a few days, were dashed, and this result severely undermined the long-term efforts of rural health workers, like himself. "The people of the MEDCAP flew off as fast as they came, leaving the people no better off. They raised hopes of miracles, and left people bitter, disillusioned and frustrated."

The mission of the JTF-B Medical Element was to provide medical support for all U.S. military forces deployed in Honduras, to provide training for deploying medical units to Honduras, and to provide humanitarian assistance on a space available basis. (Over time the mission, principles and goals became more formalized. See Jenkins, MEDCAPS and MEDRETES as Instruments of Foreign Policy.[2])

The medical practice at JTF-Bravo was basically of two varieties: hospital-based and MEDRETEs. The hospital had two operating rooms, trauma room, clinics, an all purpose ward, x-ray, laboratory, and pharmacy. There were physicians (general surgeons, orthopedic surgeon, internists, pediatricians and whoever else might come down for short training exercises), nurses, preventive medicine officer, veterinarians, dentists, administrators, corpsmen, and technicians. The hospital was like a missionary hospital which took all needy comers. The Hondurans who were admitted had significant or severe medical or surgical problems. The hospital, and the MEDRETEs, may not have contributed to long-term development of a health service, but it made a long-term difference to the patients.

The MEDRETEs were somewhat as described in the Peace Corpsman's letter. Initially (or at least during my six-month tour) the Honduran Armed Forces C-5 (Civil Affairs) would pick a village to visit. A reconnaissance flight would work out the details and make a needs assessment. On the appointed day a Chinook and a Blackhawk helicopter would carry the medical team to the field site. Then began a long day of seeing patients, pulling teeth, and vaccinating and deworming livestock. We were concerned for the development of continuity and follow - up, and did have minimal success in getting the C-5 to return to a few villages. In February 1986, a new government took office and the Ministry of Health wanted more involvement. Subsequently, they chose the villages with intent to return,

and almost invariably they took the lead by having a Honduran physician and nurse go as leaders of our team. That was considered progress because it was returning control to the civilian health authorities. In addition, we were working with appropriate counterparts and establishing goals and standards appropriate for the situation. Continuity was enhanced by returning repetitiously to several villages.

There was great enthusiasm by all, but concern that the interests of the United States and the host country might somehow be better served. In the Spring of 1986, leaders of Aesculapius International Medicine (AIM) arrived, asking good questions and seemingly with a methodology to get objective answers. AIM's statement of purpose is to "respond(s) to situations throughout the world where the local political or military situation has made it dangerous for health care workers to provide health care, or to act ethically."[3] They came with the tacit approval of the ASD/Health Affairs (Dr. William "Bud" Mayer) and the Director, Humanitarian Assistance of the ASD/ISA (Mr. Robert Wolthias). Their study proposal reflected some of the concerns shared by the military, perhaps for different reasons:[4]

> The motivation for expanding the military role in this area includes moral and humanitarian impulses and principles, awareness of the value of the goodwill that may result, counterinsurgency strategy, and the vacuum left by failures of civilian agencies to carry out effective humanitarian assistance in regions considered strategically important. As the planning for military participation continues, the emphasis at times seems to be shifting from the earlier

> motivation of humanitarianism and recognition of public relations benefits to concentration on the potential for counterinsurgency strategy and an increasing impatience with the shortcomings of civilian initiatives. The Pentagon is now examining possible roles for themselves not just in provision of humanitarian assistance, but in the much broader arena of 'nation building' as seen within the context of international security policy.

AIM hired two Spanish speaking women physicians to carry out the study. They were to visit the villages served, as well as talk to all officials at all levels concerning the outcomes of the MEDRETEs:[5]

> We propose a twelve-month study to determine current Department of Defense policy, examine its underlying theoretical framework, and analyze and evaluate its implementation by military personnel in the field. Increased military activity whether by local or foreign troops in humanitarian actions raises issues relating to those of national sovereignty, the role of the military, international humanitarian law, and human rights.[5]

Within a few months, I received a verbal report from the physician surveyors that they were finding that the MEDRETEs were doing more good than harm. This Army War College study was started in part to find the conclusions of AIM's study. The current staff of AIM has no record of a completed study nor does Mr. Wolthias ASD/ISA - Humanitarian Assistance have any knowledge of a completed study.[6] I am unaware of any other undertaking to evaluate the effectiveness of military medical humanitarian assistance. The Bibliography lists other articles germane to the topic: they have value because they are written by people of experience. However, experience is anecdotal and subjective.

My personal experience was professionally and privately gratifying. The Americans, and our Honduran counterparts, were well motivated. The U.S. Ambassador to Honduras and his country team, as well the Southern Command CINC, were active supporters. Most, but especially AID, were concerned about long-term effectiveness and whether a real difference could be made in helping the Ministry of Health develop a better health service. All seemed to agree that the goodwill of a neighbor-to-neighbor helping hand was creating a good image for both countries in the eyes of the citizens of both countries, and, in actuality, was helping people. For the Americans the training was considered invaluable. On balance, it was good. The dilemma - how to make it better?

Endnotes

One Man' View

1. John A. Chermack, Letter to Congressman Samuel Stratton, 5 September 1984, pp. 1-5.

2. Elray Jenkins, COL, Medical Civic Action Programs and Medical Readiness Training Exercises as Instruments of Foreign Policy, pp. 8-12.

3. Aesculapius International Medicine, Statement of Purpose. p. 1.

4. Richard H. Goldstein, M.D., The U.S. Military and Humanitarian Action, p. 2.

5. Ibid, pp. 3-4.

6. Robert K. Wolthius, Deputy Assistant Secretary of Defense/Global Affairs, Personal communication, 11 January 1991.

WHICH WAY FROM HERE ?

In this study historical evidence, appropriateness, effectiveness, and the lessons learned from military medical humanitarian assistance have been examined, as well as the current structure within the Department of Defense for providing that assistance. The historical evidence reviewed took place in the context of a wider military setting. However, the principles learned are as applicable to a small medical team, such as with counterdrug forces in a friendly country, as to occupation forces.

The appropriateness of the involvement of the Department of Defense in humanitarian assistance is predicated on the fact that the military may be the only presence with the expertise and capability to provide the aid. The military is also one of the few organizations that can, through its school system, produce competent and confident people for tailor-made medical missions.

Effectiveness is difficult to judge. The true test in a situation short of combat or occupation is whether a country, and the U.S. ambassador to that country, invites in humanitarian assistance and finds it of value.

The lessons learned can be reduced to one Truism, two Givens and several Principles.

Truism: Americans - commanders, medics, soldiers - will give humanitarian aid, in conjunction with their mission, whenever possible. Therefore, plan for it. True humanitarian impulse is the basic drive. Strongly present as well is the desire to win friends for our cause and to create the environment for a stable government.

First Given: The humanitarian force structure will be tailor-made. Each situation will be different. In one, medics may need to establish in-country medical training programs and jointly staff a civilian hospital. Another situation might call for committing a small team for several years. Here, U.S. medics trained in public health, sanitation and primary health care would work with their host country counterparts. All situations will call for dedicated, intelligent, and skilled people.

Second Given: For Americans, the U.S. Ambassador, and his country team, is in charge. The geographic CINC will coordinate all the military assets (except those assigned directly to the embassy) in his area of responsibility. The host nation Minister of Health, usually, controls the public health services of his country. The host country military civil affairs chief, likewise, might think he is in charge. Therefore,

diplomacy, cooperation and coordination, within legal and ethical limits, are vital.

Principles:

1. Public health first, curative care second. The goal of medical humanitarian aid is to assist in the development of a country's public health infrastructure. That requires long term, long haul commitment. Americans often prefer the gratification of short term care given to individual patients. That is appropriate for de minimus care, but not developmental policy. Public health is more than sporadic medical care. Public health includes sanitation (potable water, waste disposal), vector control, immunization, health education, medical supply, evacuation, as well as clinical services.

2. Realizable standards. The standards of quality and performance of care must be better than that currently available. American standards may be inappropriate and unattainable.

3. Train to realizable standards, not higher. Overtrained people tend either to be frustrated or leave the program for jobs commensurate with their skill.

4. Be status conscious. American representatives should not have a higher status than their host country counterparts. Otherwise, there may be inappropriate deference or resentment.

5. Second order effects. Anticipate the effects of the medical care on other interests. Health care workers may threaten the local witch doctor, a new well may put the water bottler out of business, etc. Attempt to understand and appreciate the politics of public health in the country.

6. Go native. Know, understand and respect local customs, mores and traditions. Speak, or attempt to learn, the language. Live as your counterpart would live.

7. Training U.S. medics - job skills. Require the medics to learn and practice skills that they might not be able to perform in the United States. Be consistent with the desired standards as a minimum and do not require performance beyond their training. Starting IVs, draining abscesses, providing veterinary and dental services, and teaching health education classes are examples.

8. Training U.S. medics - living skills. If living in the field, do not over-modernize. As an example, "burn-out latrines" demonstrate basic solid waste sanitation. Living should be austere and commensurate with local standards and customs.

A made-to-order medical humanitarian force will require great flexibility in its creation. A major challenge will be the force integration issues that will allow the training, equipping, and assigning of medics to teams or units that are

not uniform in structure. The Special Operations Force (SOF) medic may serve as a model, but the SOF structure is not necessarily the appropriate one for humanitarian assistance missions. An adaptation of the SOF model could be a medical - public health - education team. It could consist of an independent duty medic, another specially trained in sanitation and hygiene, and another specializing in public health education. Teams could be constructed in conjunction with local public health workers or local military personnel.

The need for military medical humanitarian assistance will continue to grow, especially as the geographic CINCs continue to request such aid in an environment of diminishing resources. The military medical community must continue to provide the leadership and the medics to meet the need.

BIBLIOGRAPHY

Aesculapius International Medicine. Statement of Purpose. Washington: 731 8th Street SE 20003. no date.

Carns, Edwin H. J., COL. "Medical Strategy." Military Review, Vol. 69, February 1989, pp.37-43.

Chermack, John A. Letter to Congressman Samuel Stratton. 5 September 1984.

DeBevoise, Ken. The Compromised Host: The Epidemiological Context of the Philippine - American War. Ph.D. Dissertation. Portland: University of Oregon, June 1986.

Erskine, John, MAJ. Oral History Interview. Washington: Medical History Unit Collection Inventory, 11 January 1977.

Foster, Gaines M. The Demands of Humanity: Army Medical Disaster Relief. Washington: U.S. Government Printing Office, 1983.

Gates, John M. Schoolbooks and Krags, The United States Army in the Philippines, 1898-1902. Westport: Greenwood Press, 1973.

Goldstein, Richard H., M.D. The U.S. Military and Humanitarian Action - An Expanding Role. Study proposal, Aesculapius International Medicine. New York: 31 January 1986.

Jenkins, Elray, COL. Medical Civic Action Programs and Medical Readiness Training Exercises as Instruments of Foreign Policy. Thesis. Carlisle Barracks: U.S. Army War College, 24 May 1988.

Kammholz, Larry P., M.D. MOC HOA, A Vietnam Medical-Military Adventure. Oshkosh: Starboard Publishing, 1989.

McPherson, Darrell G. The Role of the Army Medical Service in the Dominican Republic Crisis of 1965. Washington: Office of the Surgeon General, April 1965.

Moncrief, William H. Jr., COL. Oral History Interview. Washington: Office of the Surgeon General, Medical History Unit Collection Inventory, 23 May 1968.

Neel, Spurgeon, MG. Vietnam Studies, Medical Support of the U.S. Army in Vietnam, 1965-1970. Washington: U.S. Government Printing Office, 1973.

Taft, William H., IV. Designation of DoD Coordinator and Director for Humanitarian Assistance. Memorandum. Washington: 26 September 1984.

Taylor, James A., LTC. "Military Medicine's Expanding Role in Low-Intensity Conflict." Military Review, Vol. 65, April 1985.

U.S. Congress. Senate-House Conference Report. Humanitarian and civic assistance provided in conjunction with a military operation (sec 333). Washington: 1986.

U.S. Department of Defense. Coordination of Humanitarian and Civic Assistance in Conjunction With a Military Operation. Memorandum ASD/ISA. Washington: 10 July 1987.

U.S. Department of Defense. Directive Number (Pending): Humanitarian and Civic Assistance Provided in Conjunction with Military Operations. Washington: 1990 (pending approval).

U.S. Department of Defense. DOD Humanitarian Assistance Program. Command Briefing, ASD/ISA. Washington: January 1990.

U.S. Department of Defense, Fourth Annual Humanitarian Assistance Conference Handbook. OSD/ISA (Global Affairs), Office of Humanitarian Assistance. Washington: 17 January 1990.

U.S. Department of Defense. Unified Commanders' Conduct of Cooperative Programs with Friendly Nations. Memorandum for the Deputy Secretary of Defense. Washington: 4 November 1985.

U.S. Southern Command. Funding for Humanitarian and Civic Assistance Projects in Andean Ridge Countries. Memorandum from SCSJA. Panama City: 9 August 1990.

Wolthius, Robert K. Deputy Assistant Secretary of Defense / Global Affairs. Personal communication. Washington: 11 January 1991.

Woodard, George S. Jr., COL. The Role of the U.S. in Educating Military Medical Officers of Developing Countries. Student Essay. Carlisle Barracks: U.S. Army War College, 16 January 1968.

Uhrig, Henry T., LTC. Swords and Plowshares. Theses. Carlisle Barracks: U.S. Army War College, 4 March 1968.

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THE U.S. MILITARY AND HUMANITARIAN ACTION -AN EXPANDING ROLE

A proposal for study prepared by:
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January 31, 1986 (revised)

Recent legislation(1) passed by the United States Congress opens the way to an expanded role for the United States military in humanitarian and development assistance efforts around the world. Within a few years, under plans currently being elaborated within the context of the defense and security mission of the US Armed Forces (2), U.S. military personnel could be actively engaged in providing medical attention, directing drought and famine relief and running "nation building" projects in the third world. This expanding role will significantly alter the character of the U.S. foreign assistance effort and have effects on social and political developments in the third world. Yet it has received little public attention and thus is proceeding without benefit of informed public debate.

Until 1985, United States humanitarian assistance activities have been the primary responsibility of civilian branches of government. Executive Order 12163 of 1979(3) and Congressional Legislation(4,5) previously limited Department of Defense initiated humanitarian actions to instances integral to defense or in times of imminent danger. Legislation passed in 1984 broadens the DOD's ability to independently conduct these activities. The pressure for this change grew out of military interest in participating in humanitarian assistance as part of its build-up in Central America, but is being applied globally. The Stevens amendment to the Department of Defense Appropriations Act of 1985(1) permits the expenditure of operation and maintainance funds for humanitarian actions taking place as a part of but incidental to Joint Chief of Staff authorized training manuvers. The Denton amendment to the 1985 Armed Forces authorization bill allows the U.S. military to transport humanitarian supplies to Central America. The Denton amendment was enacted as a part of the 1986 authorization bill, and expanded to provide for world wide authority. Under this new authority, the US Military transported privately owned helicopters to assist in delivering food to remote regions of the Sudan in August, 1985. Under the Stevens amendment, US Military forces have provided a variety of health services to the people of Honduras, initiated a malaria control program in a remote sector of Ecuador, and have participated in other Medical Civic Action programs as a part of training exercises in South East Asia, the Middle East, and Africa. The Stevens

amendment is expected to be renewed as part of the 1986 Armed Forces appropriations bill. Actions conducted under the authority of both the Stevens and Denton amendments are to be reviewed by Congress in 1986.

The motivation for expanding the military role in this area includes moral and humanitarian impulses and principles, awareness of the value of the goodwill that may result, counterinsurgency strategy, and the vacuum left by failures of civilian agencies to carry out effective humanitarian assistance in regions considered strategically important(6). As the planning for military participation continues, the emphasis at times seems to be shifting from the earlier motivation of humanitarianism and recognition of public relations benefits to concentration on the potential for counterinsurgency strategy and an increasing impatience with the shortcomings of civilian initiatives. The Pentagon is now examining possible roles for themselves not just in the provision of humanitarian assistance, but in the much broader arena of "nation building" as seen within the context of international security policy (7,8).

Until this year, U.S. military participation in humanitarian assistance has been limited to five general areas, usually under civilian supervision.

1. It can provide training, equipment, and services to friendly foreign military forces engaged in civic action programs if the State Depatment approves and if Congress has provided the money.

2. If requested, and under certain statutory limitations, it can provide transportation in support of some humanitarian efforts.

3. It can support disaster relief operations upon request from appropriate civilian agencies, principally with transport, equipment, and emergency supplies.

4. It may dispose of certain foreign excess properties and donate excess medical materials or supplies for humanitarian purposes in a foreign country.

5. It may provide limited medical assistance in disaster relief and other situations, generally at the request or civilian agencies.

Medical civic actions (MEDCAP) under the renewed legislation will be similar to those that took place as part of Big Pine II in Honduras. During these exercises, from August 1983 to February 1984, the United States Army's 41st Combat Support Hospital and attached units flew Black Hawk helicopters to visit 135 rural villages in the vicinity of five of the nine major American military bases in Honduras. They evaluated 47,228 medical patients, 7,389 dental patients and extracted 21,047 teeth, while veternarians treated 37,067 animals. They assisted the Ministry of Health in the National Immunization Week in November 1983 when over 200,000 immunizations were provided to Honduran children. During some visits there were classes in basic sanitation given to waiting patients. A food distribution program was also part of some MEDCAP visits. Finally, training and assistance were provided in Honduran hospitals and health posts, and 157 inpatients and 1,434 outpatients were treated at U.S. facilities.

Malaria control, well drilling, and sanitation projects have been incorporated under current civic action program plans. In addition, refugee relief activies have been initiated in Africa.

Over the next two years, the Pentagon plans to seek additional authority from Congress to expand its role in humanitarian assistance efforts. Depending on the legislative strategy adopted, the Pentagon will either seek the limited goal of removing certain restrictions which bar it from various activities, or the more ambitious goal of making international humanitarian assistance and civic action a part of the defense mission of the United States Armed Forces.

Such changes obviously would affect the conduct and style of U.S. foreign policy. They also would raise questions about the proper role of military institutions not only in the United States, but also in those societies which receive U.S. assistance. Whether such changes in the military role, and the potential for increased military influence both in the United States and abroad, will ultimately result in the improvement of the human condition depend on the policies now being elaborated and how they are implemented. It is of general concern that these policies evolve in such a way as to support local initiatives and strengthen local civilian institutions.

There now exists a unique opportunity to examine both the evolution of these policies and the first attempts to implement them. We propose a twelve-month study to determine current Department of Defense policy, examine its underlying theoretical framework, and analyze and evaluate its implementation by military personnel in the field. Increased military activity whether by local or foreign

troops in humanitarian actions raises issues relating to those of national sovereignty, the role of the military, international humanitarian law, and human rights. The findings of this study would be analyzed with respect to these international public policy issues.

This study will determine Department of Defense policy through a series of discussions to be held:

1. with DOD planners in Washington, D.C. where a humanitarian assistance office has been established in the Pentagon. Its mandate and relationship to other governmental, nongovernmental United States and multinational agencies will be defined.

2. at the U.S. Army's Academy of the Health Sciences in Texas, whose Commandant has elaborated the potential role of military medicine in counterinsurgency warfare and "nation building". These concepts are applicable to other humanitarian actions as well.

3. with the appropriate command surgeon generals. The translation of theory and policy to the field may vary from command to command based on interpretation and needs of the region.

Field activities will be observed, with special attention paid to those in Latin America, Africa, and the Middle East. The transition from concept to practice is a difficult one for any institution. Host country perception may differ from that intended by the project's creators. It will be important to determine the impact on local institutions and the military-civilian relationship. Specific studies planned include civic actions to be held in Egypt, Jordan, Somalia and possably Omman and the Sudan as part of the regularly scheduled Bright Star maneuvers; as well as in Honduras, Ecuador, and Costa Rica as part of ongoing US Southern Commmand activities.

In providing humanitarian actions in their former colonial territories, the French government has addressed similiar issues. A review of current French policy toward military humanitarian actions will be undertaken as a part of this study for the purpose of comparison.

Most foreign military assistance programs include a training component. Foreign soldiers may be brought to the United States or a regional US military base, such as in Panama, for training. At the same time, US military training teams may be sent to train foreign troops in their

own countries. The role of the armed forces in humanitarian actions is being advanced through these training and exchange programs.(9) This study will review the degree to which humanitarian principles and the law of war, as they pertain to humanitarian assistance actions, are included in such training.

Preliminary discussions with Dr. William Mayer, Assistant Secretary of Defense for Health; General France F. Jordan, Deputy Assistant Secretary of Defense; and Mr. Robert Wolthias, Director, Humanitarian Assistance; were held on 25 February 1985. Subsequently, a preliminary study to gauge the scope of humanitarian efforts by the United States military, and the need for such a project as proposed herein was carried out from April to June, 1985. The results of that study are reflected in this proposal.

The study will be carried out by a core group of three professionals connected with Aesculapius International Medicine.

Richard Goldstein, M.D., is on the faculty at the New York University School of Medicine, and President of Aesculapius International Medicine. Dr. Goldstein has done health needs assessment in El Salvador, Brazil, Zimbabwe, and Vietnam; and monitored and reported to the U.S. Congress on humanitarian assistance projects in Central America.

Wafaa M. El-Sadr, M.D., is also on the faculty at the New York University School of Medicine. She is Vice-president and a member of the Board of Directors of Aesculapius International Medicine. Dr. El-Sadr is a specialist in infectious diseases and tropical medicine. Arabic is her first language.

Patrick Breslin, Ph.D., writer and consultant to Aesculapius International Medicine. Dr. Breslin's academic training is in political science, economic development, and international relations. He is a specialist on Latin America and speaks fluent Spanish. Last year, he evaluated U.S. military medical civic action programs in Honduras.

Additional experts are available to the core group on a consultant basis.

References

1. Department of Defense Appropriations Act 1985, sec 8103, and 1540.

2. Defense Department Task Force Report on Humanitarian Assistance, 19 June 1984.

3. Executive Order 12163 of 1979 gives the State Department policy and budgetary control over humanitarian assistance.

4. See Title 31 U.S.C. 1301; Title 10.

5. GAO investigation into military spending in Honduras during Big Pine II 1984.

6. New York Times, 8 November 1984.

7. New York Times, 3 May 1985.

8. Taylor, James A., "The Emerging role of Military Medicine in Low Intensity Conflict", Military Review, April 1985.

9. Taft, Julia, "Statement to the Independent Commisssion on Humanitarian Issues", 7 July 1983, Geneva, Switzerland.

AESCULAPIUS INTERNATIONAL MEDICINE

STATEMENT OF PURPOSE

Aesculapius International Medicine responds to situations throughout the world where the local political or military situation has made it dangerous for health care workers to provide health care, or to act ethically. For example, in a civil war, both sides are competing for the allegiance of the non-combatant civilian populations. Those prosecuting the war subvert actions usually thought of as humanitarian to political or military purposes. Food programs, relief or refugee efforts, as well as medical activities become tools to win the "hearts and minds" of the people. Often in this setting, neither side respects the principles embodied in the Geneva Conventions, and may attack a health care worker for providing health care in a neutral manner.

In response, Aesculapius International Medicine's projects attempt to return health care to the realm of a tolerated neutral human activity. For example, in first El Salvador, and later Guatemala, Aesculapius has supported primary health care projects in isolated rural areas subject to the effects of a violent civil war. The projects are community based, and center on the training and support of village health care workers. The work upholds commonly accepted public health principles, but also attempts to balance them with the curative needs of a population cut off from any other source of health care.

Five years of work in El Salvador has resulted in the establishment and survival of a network of health promoters in a highly conflicted region of the country. To maximize our chances for success, we at first limited the work of Aesculapius to focus principally on the El Salvador project. Before working outside the region, we chose another Central American country, Guatemala, as the next project site to see if what was learned in El Salvador could be adapted and applied to another conflicted setting in a country with some shared regional characteristics. We are just now beginning to share our experience in Central America with health professionals working in a similar setting in South Africa.In general for Aesculapius to work in a particular setting, requires not only the problem, but that a local nongovernmental group exists to direct and later independently continue the project.

Aesculapius International Medicine is incorporated in the State of New York under not-for-profit laws, and is a tax-exempt public foundation under Section 501(C)(3) of the Internal Revenue Code. The work of Aesculapius is strictly humanitarian, non-sectarian, and non-partisan. Aesculapius upholds the principles set forth in the Universal Declaration of Human Rights and believes that health care is a human right. To preserve its nonpartisan voluntary status, Aesculapius does not accept funds from the United States government or other organizations with ideological goals.

Dr. Whitehead

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Congressman Samuel Stratton
House Office Building
Washington, D.C. 20515
United States of America

5 September 1984

Dear Mr. Stratton:

I am John Chermack, a Peace Corps Volunteer from Schenectady, New York. I have been in Honduras for six months now, living and working in Marcala, a pueblo of about 6,000 people. I am a public health educator, and work with local health workers, teachers, school and directly with the local people. I strive to teach that it is possible to improve one's own standard of health, hygene and nutrition through education, hard work and acceptance of responsibility for changing situations encountered. This calls for drawing upon local resources as the driving force for that change, as well as using reliable federal and international assistance as a catalyst in the development process. With this in mind, I write to inform you of what I consider a regretable situation, in hopes that you might be able to prevent it's repetition.

On Saturday, the fourth of August of this year, Marcala's Centro de Salud (Health Center), where I work, had the "opportunity" of hosting a MEDCAP, a medical brigade put on by the Army and Air Force of the United States of America. Being a member of the health team here in Marcala, I felt obligated to offer my assistance. Later I was to deeply regret my involvement, and have severe misgivings concerning the value of such operations.

The brigade arrived by helicopters (two), bringing six doctors, two dentists, and an array of support staff. Several footlockers of prescription and non-prescription drugs were brought in and a make shift pharmacy was set up. People lined up nearly five hours before the MEDCAP was to begin, in order not to miss seeing one of the "Experts" from the U.S.A. By the time the doctors commenced to see them, over five hundred fifty people had gathered, and there was nearly a feeling of religious devotion and expectation of that miraculous cure sought by those on the verge of dispair. That which followed contradicted all I know of sound medical practice and devolopment strategy.

While the attitude of most of the soldiers I encountered was one of deep concern for the people and the poverty they suffer, I believe they were working in a system that precludes alleviating that suffering in any tangible way and actually sustains the the causal factors. Even some of the medical personel realized the shortcomings of the MEDCAP as they explained to me:

"Other than P.R. for the Army, we don't do much of anything."

"We do a little 'VooDoo' and make them think they're going to get well."

"We don't hurt anyone and if we get lucky maybe we help someone."

To tell the truth, I doubt these officers have any idea of the harm they do, how they undermine the cedibility of local health professionals, rob people of their incentive to work for change and control of their own lives, and accomplish nothing in the way of true health care. Once the people get over their excitement, they too realize how worthless the whole thing was, and even the goal of good public relations is not realized. After reading the following description of what was perpetrated in the name of health care, I am sure you will agree that if the armed forces need to improv public relations, a fried chicken picnic or a carnaval would serve them better.

For the first two hours of the MEDCAP I was asked to translate for two of the doctors, as there was a shortage of personel with a proficiency in Spanish. In those two hours I saw only one person actually examined, as doctors listened to complaints and wrote out prescriptions. I am not a doctor, but am confident that I could have treated any one of those patients just as well. People had refused to be seen by the local doctor, and yet he is the one who will be there if follow up care is needed. He is the one with a responsibility and committment to the people, and can offer them care on a regular basis, without the confusion and rush of the mob scene the MEDCAP had become. I calculated that there was no way any person could have been seen for more than 140 seconds. Imagine your reaction if your doctor gave you less than two and a half minutes and called it professional consultation.

The dentists too seemed to provide no service that could not have been rendered by our local odontologist. Sure, they pulled alot of teeth, but that is not a need, for anyone can do that if need be. The true need in dental health is education as to hygene, and prevention of tooth decay and gum disease. People here do not make regular visits to the dentist even though there is one available for a nominal fee (if needed that too will be waived). A dentist is seen as just a tooth puller, and our MEDCAP reinforced this notion. The people loose out in the long run, and my classes on dental health are contradicted.

For the next three hours I worked the pharmacy, dispensing drugs and giving oral explanation for their usage, as few campesinos can read, even though directions were in Spanish. I was completely overwhelmed by the mass of people we had to serve, and the confusion that followed made me quite certain that my verbal instructions were probably not even heard, let alone comprehended. I cannot imagine a woman with three or four children, each recieving three or four medications, remembering who gets what, how much and when. And remember the officer who said that we don't harm anyone. In reality with a little luck they won't poison anyone.

They also showed up with an inadequate supply of antibiotics, and we were forced to give half dosis. I don't know how much you are familiar with antibiotics, but it is very important that people take the entire routine of medication to be effective. In fact, half dosis may be just enough to lower the body's natural defenses leaving the person uncured, and susceptible to further infections. When I questioned the doctor concerning this practice, I was told, "Even if we gave them all they need, they will probably take half and sell the rest." Rather than excusing this action, to me it points up the need for competant health education. Instead, the MEDCAP reaffirms the idea that people just have to take a pill and they'll be okay. My teaching that people can have control over their own health is once again contradicted.

The prescriptions that the doctors wrote were nothing more than scraps of paper with the name of a drug. Patients' names and dosis became a rarity as time progressed, as the doctors were unable to keep up with the flow of people. As I said, I am not a doctor, but in working the pharmacy I am certain that I decided what dosis would be appropriate for a giv patient in no less than fifty cases. And people thought they were getting expert medical care.

Every child there was given medication for worms, reguardless of whether or not they had worms. People thought this would cure all types of ameobas, paracites and all worms. The medicine actually cures just two types of worms, and I believe there are over a dozen types to be found here. More than that, without an education as how to prevent worms, all those children will have them back within about two weeks. But why should a campesino go though the trouble to boil water and wash vegetables when he can just take that magic medicine?

Other medicines have little or no real medical effect, such as visine, vitamins, and tylenol or aspirin. But again there is problems with the wholesale distribution of such items. Doña Concepcion who was given visine and vitamins for cataracts now realizes what a scam the 'VooDoo' really was. At first elated, she is now bitter and depressed, knowing that she is going blind, and the Gringo Military lied to her.

Vitamins in and of themselves seem like something that anyone could benefit from, yet the practice of giving a person a two week supply to aid a cronic condition needs to be examined. I teach that for improved health and better nutrition, people need to spen their scarse and hard earned financial resources on nutritious food such as eggs, milk and vegetables. I will be teaching gardening t help fulfill this need and at the same time alleviate some of thei dependance on others. To recieve a free sample (as there is not e to call it a theraputic supply) from a U.S. doctor is a powerful d onstration to them that they need pills to be healthy, and that th themselves are incapable of improving their lives. It says that to improve they must rely on the good will of those in power or wi money, which is power as well.

I will admit that there are cases where medicine is truely ne as there never seems to be a consistant supply of needed medicine out in the campo. But even for those who recieved needed medicati recieving it one weekend every two or three years is a negligible advantage. If the military (and Congress who appropriates their funding) truely wanted to help the people here, they could use the thousands and thousands of dollars spent on the MEDCAPS to provide a regular supply of medicine to be dispensed by local health professionals that can insure an education as to its proper use. The could invest in labratory equipment for health centers, or in the construction of health centers or hospitals. They could finance t sending of Honduran doctors to remote Campo areas. A well informe and imaginative person can think of many ways this money could hav been spent, or not spent at all.

I am sure you see that this MEDCAP was in no way a service to the people of Honduras. Doctors who fly in and distribute medicin without staying around to see if there is an alergic reaction are menace. They undermine local professionals, contradict health educators, and reinforce age old ideas that people cannot help themselves.

I regret having been involved with the MEDCAP as I have now associated myself with the military in the eyes of many people her in Marcala, and that will take time to rectify. Peace Corps Volun teers are known to disassociate themselves from the military, and I now see the wisdom in that practice. The people of the MEDCAP flew off as fast as they came, leaving the people no better off. They raised hopes of miricles, and left people bitter, disillusioned and frustrated. I have communicated my feelings on these issues to Gail Morrow, Associate Peace Corps Director in charge of the Health Sector in Honduras. I have suggested that no Peace Cor personel be involved in future MEDCAPs.

Now, a month later, I must face the people of Marcala and answer their questions as to 'why?'. The public relations angle as a reason for such operations has long since died in Marcala. I can only reason that such initiatives are undertaken to appease the public and Congressional conscience concerning the role of the military here in Central America. Back around April of this year there was a rash of newspaper reports in publications such as USA Today, the Chicago Tribune, and others citing the wonderful humanitarian accomplishments of the U.S. military concerning health. I hope this letter sheds more light on the situation than the press was capable of doing.

I do not pretend to know all the strategy, politics and the like that are involved in deciding whether or not to provide military aid to a country like Honduras, but I do know that military aid should be weighed on its own merit, not on purported humanitarian benefits. I would appreciate hearing from you, and have a keen interest in your views on Central America and the aid policies of the United States. I am developing my own view of the role of U.S. military in the area, USAID, development assistance, and even the role of Peace Corps. I would enjoy your input immensely.

I appreciate your time and also hope you can sympathize with my concern. I attentively await your responce.

Sincerely,

John A. Chermack

cc. Senator Daniel Patrick Moynihan
Senator Alfonse M. D'Amato
Gail Morrow, APCD
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